HEALTH QUESTIONNAIRE

NAME: _____

AGE _____ HEIGHT _____ WEIGHT _____ BMI _____

Are you currently using tobacco? ☐ Yes ☐ No If yes, what year did you start? _____
Packs per day _____ Smokeless tobacco? Yes ☐ No ☐
Have you used tobacco in the past? ☐ Yes ☐ No
If yes, what year did you start? _____ What year did you quit? _____

Alcohol use ☐ Never ☐ Rare ☐ Moderate ☐ Daily
Recreational drug use ☐ Yes ☐ No If yes, what drug(s)? _____
Are you approved for medical marijuana use? ☐ Yes ☐ No

Have you ever had an allergic reaction to any medications? ☐ Yes ☐ No
If yes, which medications and what type of reaction? _____
Have you ever had an allergic reaction to X-ray or contrast dye? ☐ Yes ☐ No
If yes, please describe: _____
Have you ever had a latex allergy? ☐ Yes ☐ No Have you ever had a tape allergy? ☐ Yes ☐ No

Prescription Medications	Dosage (mg)	Frequency (one, twice per day, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Non-Prescription Medications (including over-the-counter drugs, supplements, herbs, vitamins, aspirin, etc)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken cortisone/steroid drugs? ☐ Yes ☐ No
Have you ever had blood products transfused? ☐ Yes ☐ No
If yes, when? _____ Where? _____

Please check illnesses that have occurred in any of your **blood relatives**, and **list which relative(s)**:

☐ Bleeding tendencies_____ ☐ Diabetes _____
☐ High blood pressure_____ ☐ Nervous disorder _____
☐ Cancer (type)_____ ☐ Heart disease _____
☐ Kidney disease _____ ☐ Stroke _____

Please check illnesses that you have had or currently have:

☐ Asthma	☐ Bleeding tendencies	☐ Blood clots	☐ Bronchitis
☐ Cancer	☐ Diabetes	☐ Elevated cholesterol	☐ Glaucoma
☐ Heart disease	☐ Hepatitis	☐ HIV	☐ High blood pressure
☐ Jaundice	☐ Kidney disorder	☐ Nervous disorder	☐ Obesity
☐ Pneumonia	☐ Reflux/peptic ulcer disease	☐ Rheumatic fever	☐ Stroke/TIA
☐ Sleep apnea	☐ STD	☐ Tuberculosis	☐ Thyroid disorder

☐ Other _____

**********PLEASE COMPLETE OTHER SIDE. THANK YOU**********

SYSTEMIC REVIEW

SKIN:

Skin diseases	NO	YES
Fragile skin/burn easily	NO	YES
Hives, eczema, rash	NO	YES
Frequent infections or boils	NO	YES
Cold sores/fever blisters	NO	YES
Abnormal pigmentation	NO	YES

HEAD, EYES, EARS, NOSE AND THROAT:

Dizziness or transient episodes of loss of consciousness	NO	YES

RESPIRATORY:

URI (cold) now	NO	YES
Asthma or wheezing	NO	YES
Difficulty breathing/shortness of breath	NO	YES

GENITOURINARY:

Frequent urination	NO	YES
Burning or painful urination	NO	YES
Blood in urine	NO	YES

CARDIOVASCULAR:

Chest pain or angina	NO	YES
Heart murmur	NO	YES

HEMATOLOGIC:

Are you slow to heal after cuts?	NO	YES
Heavy bleeding after surgery/ tooth extraction	NO	YES
Abnormal bruising or bleeding	NO	YES

WOMEN ONLY:

Are you pregnant?	NO	YES
During pregnancy do you have hypopigmentation or masking?	NO	YES
Do you have regular periods?	NO	YES
Are you currently going through menopause?	NO	YES

Date of last menstrual period: _____

Date of most recent mammogram _____

Previous operations or hospitalizations. Please list procedure, year, and describe anesthesia complications (if any):

_____ _____

_____ _____

Have you had any serious injuries, broken bones, etc? ☐ Yes ☐ No

If yes, please list: _____

Patient or Responsible Party Signature: _____ Date ___/___/___